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# Standing Committee on Health

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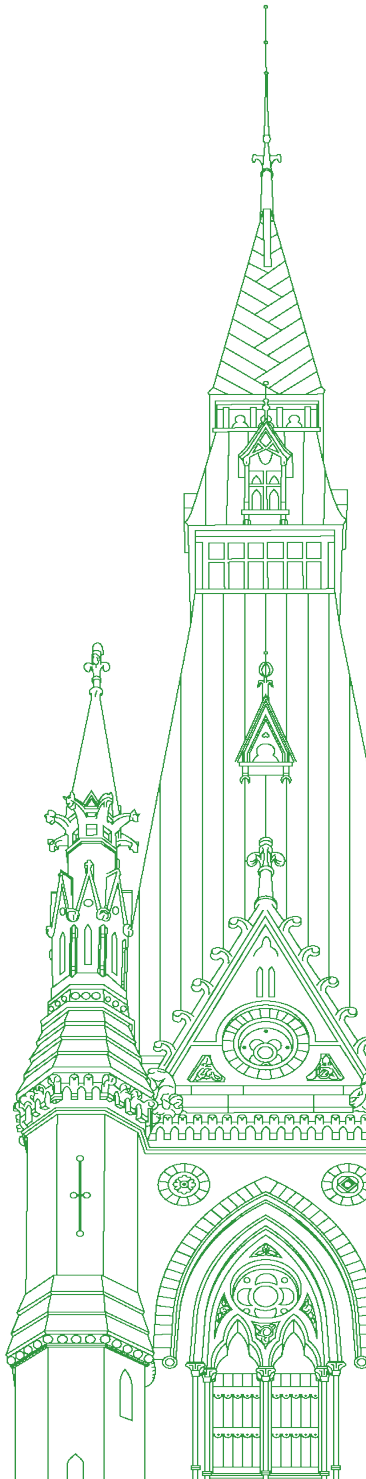
**NUMBER 105**

Thursday, February 29, 2024



Chair: Mr. Sean Casey

# Standing Committee on Health

**Thursday, February 29, 2024**

● (1100)

[*Translation*]

**The Vice-Chair (Mr. Luc Thériault (Montcalm, BQ)):** I call this meeting to order.

Welcome to meeting number 105 of the House of Commons Standing Committee on Health.

Today's meeting is taking place in a hybrid format, pursuant to the Standing Orders. To ensure that the meeting runs smoothly, I'd like to pass on some instructions to the witnesses.

Please wait until I recognize you by name before speaking. For those participating by video conference, click on the microphone icon to activate your mike, and please mute yourself when you are not speaking.

As far as interpretation is concerned, those taking part remotely using Zoom have the choice, at the bottom of their screen, between floor, English or French. Those in the room can use the earpiece and select the desired channel.

As a reminder, all comments should be addressed through the chair.

In accordance with our routine motion, I am informing the committee that all remote participants have completed the required connection tests in advance of the meeting.

Pursuant to Standing Order 108(2), the committee is resuming its study of the opioid epidemic and toxic drug crisis in Canada.

I would like to welcome the witnesses joining us today.

Appearing as an individual is Dr. Elaine Hyshka, associate professor and Canada Research Chair in Health Systems Innovation, School of Public Health, University of Alberta.

From the University of Toronto, we also have Dr. Meldon Kahan, associate professor, Department of Family Medicine.

Joining us from Simon Fraser University is Dr. Bohdan Nosyk, professor and St. Paul's Hospital CANFAR chair in HIV/AIDS Research.

Also with us is Dr. Marie-Ève Goyer, physician, Clinical and organizational support team in addiction and homelessness.

We will now proceed to opening statements. You will each have up to five minutes for your statement. We'll begin with Dr. Hyshka, followed by Dr. Kahan, Dr. Nosyk and Dr. Goyer.

Dr. Hyshka, you have the floor for five minutes.

[*English*]

**Dr. Elaine Hyshka (Associate Professor and Canada Research Chair in Health Systems Innovation, School of Public Health, University of Alberta, As an Individual):** Thank you for the opportunity to appear today. My name is Elaine Hyshka, and I am a Canada research chair in health systems innovation, and an associate professor at the University of Alberta's school of public health. I am joining today from Edmonton, on Treaty No. 6 territory, the traditional lands of first nations and Métis people.

My opening remarks outline the current situation in Alberta, how we got here and where we need to go provincially and nationally to achieve sustained reductions in drug-related morbidity and mortality.

In Alberta, 2023 will be the worst year on record for opioid poisoning deaths. Between January and November, we lost five people per day—a total of 1,706 people—to fatal opioid poisoning. This annual death count, though still incomplete, is nearly 19 times higher than that observed at the height of the prescription opioid crisis in 2011, when 91 Albertans died from opioid overdose. The situation is so severe that it is contributing to declines in population life expectancy.

What accounts for this substantial increase in mortality? The preponderance of evidence indicates that the exponential increase in deaths in Alberta is the result of fundamental and, presumably, permanent shifts in the illegal drug supply, which have made using drugs much more dangerous than ever before. It is not the result of a significant increase in the prevalence of addiction or opioid use disorder. We currently have no data showing that there has been a huge increase in the number of people who have developed opioid use disorder or addiction in Alberta since 2011. Instead, well-intended efforts to reduce prescription opioid use beginning in 2012 led to a rapid reduction in prescribing and a 50% reduction in the total population flow of prescription opioids by 2018. Unfortunately, the death rate did not decline. It surged as the illegal drug market moved to fill this gap with highly toxic, clandestinely produced novel synthetic opioids. Complicating the situation further are increasing rates of stimulant co-use, and contamination of opioid products with benzodiazepines and other sedatives.

We have now lost 10,060 Albertans to toxic drugs. To put this number in perspective, 3,861 more people have died in this crisis than have died from COVID-19 in Alberta. Most people dying are young and middle-aged. Many are first nations people, who as a result of colonization, racism and discrimination, die at seven times the rate than non-first nations people in Alberta, contributing to a seven-year decline in their life expectancy between 2015 and 2021 alone. The potential years of life lost and the impacts on surviving children, parents, families, friends and communities are enormous, and they are devastating.

Reversing this trend will require an evidence-informed public health response that we have yet to see anywhere in Canada. COVID-19 demonstrated how coordinated and well-resourced public health efforts can achieve rapid advances in science and avert substantial morbidity and mortality over time. We need a similar societal response to toxic drugs to save lives, promote health equity, reduce pressure on health systems, and avert billions of dollars in lost economic productivity attributable to toxic drug deaths.

Critical components of this response include estimating the number of Canadians at risk for drug poisoning, and then using this data to optimize and expand proven interventions, like opioid agonist treatment and supervised consumption, to ensure we meet needs across the population. It also includes acknowledging the reality that the majority of people at risk for drug poisoning in Canada do not meet criteria for opioid use disorder and will not routinely seek health care for drug use. This means continuing to trial novel models of prescribed and non-prescribed safer supply with the aim of reducing exposure to toxic drugs. Equally important, we must address the underlying factors that increase vulnerability to drug-related harm. This requires concerted efforts to improve management of chronic pain and mental health conditions, improve health and social status of indigenous peoples, and reduce rates of housing insecurity and poverty nationally.

Finally, we need to invest in implementing and evaluating community-wide, universal prevention programs for children, youth and families, which have strong potential to reduce rates of early adolescent drug use, and would pay dividends in many realms of social life.

Thank you again for the invitation to appear today and for your thoughtful study of this issue.

● (1105)

[*Translation*]

**The Vice-Chair (Mr. Luc Thériault):** Thank you, Dr. Hyshka.

There is currently a vote in the House. I would like to ask my colleagues if they wish to continue with the meeting or if they wish to take a break while the vote takes place.

[*English*]

**Mr. Majid Jowhari (Richmond Hill, Lib.):** Continue with all the testimony.

[*Translation*]

**Mrs. Laila Goodridge (Fort McMurray—Cold Lake, CPC):** Mr. Chair, I suggest that we hear the opening remarks of the other witnesses and then take a break for the vote.

Does everyone agree?

● (1110)

**The Vice-Chair (Mr. Luc Thériault):** Everyone is in agreement. We will therefore continue the meeting.

The next witness is Dr. Kahan.

Mr. Kitchen, would you like to make a comment?

[*English*]

**Mr. Robert Kitchen (Souris—Moose Mountain, CPC):** Thank you.

I have a point of clarification.

We have three more witnesses. Is that correct? They're going to speak for 15 minutes and we have 30-minute bells.

Okay.

[*Translation*]

**The Vice-Chair (Mr. Luc Thériault):** Yes, that's right.

Mr. Johns, you have the floor.

[*English*]

**Mr. Gord Johns (Courtenay—Alberni, NDP):** Can we agree, when we break, to vote here from our apps?

Okay. Thank you.

**Mr. Robert Kitchen:** I'm sorry. I believe I should be in the House.

[*Translation*]

**The Vice-Chair (Mr. Luc Thériault):** So we're going to continue the meeting and hear the evidence. Then we'll take a break for the vote.

Dr. Kahan, you have the floor for five minutes.

[*English*]

**Dr. Meldon Kahan (Associate Professor, Department of Family Medicine, University of Toronto, As an Individual):** Thank you for giving me the opportunity to speak on the opioid crisis. My talk will focus on opioid agonist treatment—or OAT—and safer supply.

Opioid agonist medications, including methadone, buprenorphine and slow-release oral morphine, are usually dispensed under supervision at the pharmacy. Take-home doses are given when the patient reduces high-risk opioid use. All four medications are long-acting, potent opioids. At the right dose, they relieve withdrawal symptoms and cravings for a full 24 hours.

Research has shown that opioid agonist therapy reduces opioid use, injection-related infections and overdose deaths, even among people who use fentanyl. Unfortunately, only a minority of fentanyl users are engaged in opioid agonist treatment, and retention rates may be declining. There are several strategies to improve access to OAT and to improve treatment retention rates.

Opioid agonist treatment should be available, on site and immediately, to patients in emergency departments and hospitals, withdrawal management services and rapid-access clinics. In order to accomplish this, emergency departments and hospitals should have on-site addiction services.

Opioid agonist treatment should be available to people regardless of where they live. This can be accomplished through virtual care. Alberta's virtual opioid dependency program is highly successful and a model for the rest of the country.

There is a need to pilot and evaluate innovative medication protocols that provide quick and substantial relief of withdrawal symptoms and cravings—for example, methadone combined with slow-release oral morphine.

Community clinics that provide opioid agonist treatment should have on-site access to wraparound services—that is, primary care, mental health services and case management.

Now I'd like to discuss, briefly, safer supply programs. In these programs, hydromorphone tablets are dispensed to high-risk opioid users, sometimes in combination with opioid agonist treatment. Several studies have found that these programs are associated with a reduced risk of overdose. However, safer supply has not been directly compared to opioid agonist treatment with respect to overdose rates or rates of injection-related infections. The programs typically dispense hydromorphone tablets as a take-home medication. Patients are sometimes prescribed 30 to 40 tablets per day to take home. Safer supply patients might sell these tablets, which is called “diversion”, or they might inject them.

Diversion of take-home hydromorphone tablets appears to be common, based on clinician reports, reports from patients and families, media reports and qualitative studies. Diversion has been a major factor in other drug epidemics, including the OxyContin epidemic of the nineties and early 2000s. Reports indicate that hydromorphone tablets are being sold not just to people who use fentanyl but also to youth and to people on opioid agonist therapy. Hydromorphone tablets are very inexpensive, and even high school children can afford them. Criminal gangs are clearly involved, and these tablets are now being sold in remote communities.

Researchers in Canada have not looked at the harms of diversion and take-home hydromorphone tablets, but early research has found that youth who used diverted prescription opioid tablets were at higher risk for subsequently injecting the tablets and for switching to heroin. I personally have had patients who switched from diverted hydromorphone tablets to fentanyl. Fentanyl is also inexpensive and produces a more sustained euphoria and withdrawal relief than the tablets.

Unsupervised injection of hydromorphone tablets is also a serious problem. Evidence indicates that injection of prescription opioids increases the risk of life-threatening bacterial infections such as endocarditis.

There are several practical and evidence-based strategies that safer supply programs can undertake to improve the safety of their programs for patients and the public.

One strategy is to dispense hydromorphone tablets under supervision. Research has shown that supervised dispensing of opioid agonist medications markedly reduces the harms of diversion and unsupervised injection, while having minimum impact on treatment retention rates.

● (1115)

Another strategy is to combine hydromorphone with optimal doses of opioid agonist medications. Opioid agonist medications are long acting, and, thus, more effective at relieving withdrawal symptoms than hydromorphone tablets. OAT will also reduce the need to prescribe large numbers of hydromorphone tablets.

[*Translation*]

**The Vice-Chair (Mr. Luc Thériault):** If you could wrap up, Dr. Kahan, your time is up.

[*English*]

**Dr. Meldon Kahan:** I'm basically done. Thank you very much.

[*Translation*]

**The Vice-Chair (Mr. Luc Thériault):** Dr. Nosyk, you now have the floor.

[*English*]

**Dr. Bohdan Nosyk (Professor and St. Paul's Hospital CANFAR Chair in HIV/AIDS Research, Faculty of Health Sciences, Simon Fraser University, As an Individual):** Good morning. Thank you for the invitation to attend this meeting.

My name is Bohdan Nosyk. I'm a professor and St. Paul's Hospital CANFAR chair in HIV/AIDS research at the faculty of health sciences at Simon Fraser University. I'm also senior author of a study evaluating B.C.'s risk mitigation guidance, what I'll call "RMG". It was later termed “prescribed safer supply”, and was published in the British Medical Journal in January 2024.

I'll focus my opening statement on this study, as I know it is of interest to this committee.

The study was conducted at a true provincial scale—

[*Translation*]

**The Vice-Chair (Mr. Luc Thériault):** Excuse me, Dr. Nosyk. There is no interpretation at the moment.

[*English*]

**Dr. Bohdan Nosyk:** I'm sorry. Can you repeat that?

[*Translation*]

**The Vice-Chair (Mr. Luc Thériault):** There was no interpretation, but it's working now.

You may continue with your speech. We apologize for any inconvenience.

[*English*]

**Dr. Bohdan Nosyk:** Okay. Are we ready?

Good morning. Thank you for the invitation to attend this meeting.

This study was conducted at a true provincial scale using B.C.'s linked health administrative datasets. My research team has specialized in the use of these data over the past 17 years and has been supporting the province's response to the overdose crisis since its declaration.

In its first 18 months, just under 6,000 of the estimated 250,000 opioid and psychostimulant users in British Columbia accessed the program. These 6,000 included just over 5,000 people with an opioid use disorder, of whom we estimate there are over 100,000 in British Columbia.

Those accessing the program tended to have long histories of substance use disorders, were socially marginalized and were at high risk of overdose death. As the program was designed to reduce the risk of overdose and death among recipients, we focused on these outcomes to determine whether the initiative had its desired effect. We otherwise focused on the immediate effects of RMG dispensations given the fact that—like birth control pills or insulin for diabetes or even opioid agonist treatment—their effects should only be expected to persist while in use.

As the guidance was issued provincially and on an emergency basis at the onset of the COVID-19 pandemic, a randomized control trial was not possible. As such, a population-based study using extensive linked health administrative data represents a best possible study design. Moreover, we executed the study at the highest possible methodological standard. As noted, it was recently published in one of the highest-impact medical journals.

The intended mechanism of the RMG program was to separate individuals from the toxic illicit drug supply. Our findings suggest this mechanism was realized. People had lower risk of death while they were receiving RMG dispensations, and more frequent receipt was associated with a stronger protective effect. That's a crucial piece of evidence. It's what we call a “dose response” effect, and it's one of the key conditions that we look for in a causal effect in epidemiology.

These effects were independent of any concurrent opioid agonist treatment prescription or other potential confounding factors that were apparent at baseline or which may have changed over the course of time after individuals initiated RMG. These effects otherwise held true, whether we considered drug-related or all-cause mortality, and we found comparable effects for stimulant RMG dispensations, though far fewer people received them and so there was a greater degree of uncertainty in these findings.

The risk mitigation guidance has been a controversial program, drawing criticism within B.C. and across Canada since its implementation long before our study's publication. Scholarly debate—that is, debate based not on ideology or anecdote but on scientific evidence—is a useful and constructive part of the decision-making process. In that spirit, our team systematically and with additional analysis and evidence addressed each of the critiques we received after our study was released via public presentation delivered on February 7, which has been posted online.

I've made this presentation and all other peer-reviewed articles and reports that I'll be referring to available to the committee; I think we need some time for the French translation to come through.

To summarize, our study demonstrated that for the relatively few people who were able to access it, the RMG program or prescribed safer supply saved lives.

Moving forward, we hope these facts and the lives of some of the most vulnerable Canadians are sufficiently considered and will inform debate and decisions about this intervention, one of a continuum of different services that we require to address the opioid crisis.

Thank you.

● (1120)

[*Translation*]

**The Vice-Chair (Mr. Luc Thériault):** Thank you, Dr. Nosyk.

Dr. Goyer, you now have the floor for five minutes.

**Dr. Marie-Ève Goyer (Physician, Clinical and organizational support team in addiction and homelessness, CIUSSS Centre-Sud-de-l'Île-de-Montréal):** Good morning.

[*English*]

I'll be doing my introduction in English, but my talk in French. I'm happy to take questions in English or French—whatever works best.

First, thank you for having me here. I also thank you in the name of my patients, who are dying very regularly.

I'm happy to see that we are all together in the same boat now, trying to find solutions together. It's very important for me and my patients.

I'm an “all addictions” doctor now. I have been doing this for 20 years as an in-patient and outpatient doctor. I have a master's degree in public health and a certificate of added competence in addiction medicine.

I am the chief of addiction and homelessness medical services in downtown Montreal. I have been working for many years now in the low-threshold opioid use disorder clinic. I'm an OAT prescriber. I'm a safer supply prescriber.

I am also the director of the ESCODI team, which would resemble what you know about BCCSU, or META:PHI in Ontario. What we do in my team is offer clinical tools and build guidelines for the whole province of Quebec.

I'm also a co-chair for CRISM. I had a chance to work abroad with Doctors of the World to help implement OAT in low-threshold countries.

● (1125)

[*Translation*]

What I want to say to you today, in two parts, is very similar to what has been said so far. First of all, as a physician, I like to have a clear diagnosis before discussing treatment. The current diagnosis, in 2024, is not a diagnosis of drug diversion or a diagnosis relating to pharmaceutical products, but a diagnosis of drug contamination on the illicit market.

I'd like you to imagine an iceberg. On top of the iceberg, there are deaths from opioid overdoses. My colleagues have set out very clearly what needs to be done. We know a number of things that work. We need to promote them even more, and above all we must not back down. We need to move towards things that work, not only access to treatment and molecules such as methadone, but also a safer supply. We can talk about this again if you like. At the moment, we're not doing any real safer supply. What we do is prescribe drugs, under the supervision of professional bodies, in a clear, highly defined clinical context for specific patients, following a rigorous assessment.

What works? Supervised injection services, access to consumption equipment and naloxone, and drug analysis services. We must have these services now and everywhere. In 2024, it's not right that most emergency departments in Canada don't have access to treatment or takeaway naloxone. It's not right that, in most provincial prisons, inmates don't have access to treatment and that you can leave a Canadian medical school without being able to prescribe methadone. So there's a real urgency to put in place the things that work. That's the tip of the iceberg.

What lies beneath? My colleague, Dr. Hyshka, addressed this very well. We need to ask ourselves who is currently dying. We need to think about social inequalities in health and the social determinants of health. Our health care system is neither truly accessible nor truly universal. Our health care system is inverted, whereas it's the people who are the sickest and have the most comorbid health problems, such as people with mental health problems, the homeless and first nations people, who should be the first to receive integrated and comprehensive services.

We need to ask ourselves why this is still not the case, despite the crisis. So we're going to have to talk about stigmatization and control, in other words, public health policies that control substances. We need to be creative and innovative in revising our public health policies. We need to talk about decriminalization. We need to realize that our current policies perpetuate social inequalities in health and perpetuate the vicious circle of poverty and marginalization. As such, we need a robust response that focuses first and foremost on those who are most likely to die and who are most vulnerable.

**The Vice-Chair (Mr. Luc Thériault):** Thank you very much, Dr. Goyer.

I'm going to suspend the meeting for 20 to 25 minutes while we vote.

● (1125)

(Pause)

● (1155)

**The Vice-Chair (Mr. Luc Thériault):** If you don't mind, since we have a quorum, we'll resume the meeting. Mr. Kitchen should be here shortly. The meeting has been interrupted for more than 25 minutes.

Before we resume, I would like to ask the members of the committee if they are prepared to continue until 1:30 p.m. at the latest. I'll also ask the witnesses.

**Mrs. Laila Goodridge:** Yes.

**The Vice-Chair (Mr. Luc Thériault):** That's perfect.

Are the witnesses also available for questions until 1:30 p.m.?

Okay, I see that the witnesses are.

I have a third request. If the first vice-chair does not arrive, would you allow me to ask my questions?

**Mrs. Laila Goodridge:** Yes.

**The Vice-Chair (Mr. Luc Thériault):** Thank you.

Ms. Goodridge, you have the floor for six minutes.

**Mrs. Laila Goodridge:** Thank you very much, Mr. Chair.

I'd also like to thank the witnesses for being with us.

[*English*]

Thank you to our witnesses.

It's a really important subject, as you guys all know. I have a few questions. At the end of this, we're hopefully going to have a report, and in the report we'll have a series of recommendations. I truly think it's important to make sure that we're looking at actions as we're moving forward through this.

I will start with Dr. Kahan. You talked about the importance of OAT therapies in addiction treatment. I was wondering if you could expand a little bit on Alberta's model when it comes to the virtual opioid dependency program, how that works and how you think that could possibly be spread across the country.

**Dr. Meldon Kahan:** Yes. I think the Alberta model has been highly successful. They are starting thousands of people in the same day on opioid agonist treatment, and that includes people in remote communities, people who have attended emergency departments or hospitals, and this is the way to do it.

Canada has such dispersed, geographically distant communities and we need to get OAT to where people are in their communities—in the hospital, in the emergency departments—and virtual care is an efficient way to do it. They have 24-7 services. I understand it's not just virtual care; they have connections to prescribers, nurse practitioners and physicians as well as to pharmacies, so I think it's a very good model to make sure that people in remote communities and people who lack transportation, and who are in hospitals and emergency departments, have access to care.

**Mrs. Laila Goodridge:** Thank you for that.

I recently toured the arrest processing centre of the Calgary city police. They actually have the ability to offer people who were recently arrested access to the VOPD program right from the arrest processing centre, and they were telling me of some of the successes they had with this really cool build-out.

[*Translation*]

Dr. Goyer, you also talked about opioid agonist treatment, or OAT.

[*English*]

I was wondering if you could possibly talk about what you see as some of the shortfalls in accessing OATs across the country and how you would increase people's access to OAT therapy.

[*Translation*]

**Dr. Marie-Ève Goyer:** Thank you for the question.

As I said, we need to make this a priority and build a bit on the models we use to treat chronic diseases. Opioid dependence is obviously much more complex, but the models for organizing services and training professionals to treat chronic diseases, such as diabetes and cardiovascular disease, are very pertinent, in my opinion.

As I said in my presentation, we're starting from a long way off. Among the easiest measures to put in place, first of all, we could make addiction training compulsory in all medical faculties, not only for doctors, but also for pharmacists, nurses and people who accompany patients on a psychosocial level. So training health care professionals is the first thing to do.

The second thing to do concerns ethical responsibility. If I take you into the emergency room when you're having a heart attack and all I do is give you an electric shock and send you home without medication, without management and without follow-up, I'm going to lose my licence to practice. We know what works for opioid addiction. When a patient presents to the emergency department because of an overdose, we can no longer simply give him naloxone and discharge him. Patients must be offered treatment immediately. There must be addiction specialists in hospitals who can advise doctors, teams, even patients, and then ensure proper follow-up—

● (1200)

**Mrs. Laila Goodridge:** Thank you.

Unfortunately, I have to interrupt you as I have very little speaking time and want to ask more questions.

[*English*]

Dr. Nosyk, what are the barriers to getting OAT in Ontario?

In anecdotal conversations I've had, people talk about the issue with the actual payment and how expensive OAT therapies are. Is that an issue in Ontario?

**Dr. Bohdan Nosyk:** Well, I'm from B.C.

**Mrs. Laila Goodridge:** I'm sorry—in B.C.

**Dr. Bohdan Nosyk:** We've expanded access to OAT enormously over the past 10 or 15 years. That has been getting more doctors on board by reducing the restrictions and the requirements for licensing to get doctors to be able to prescribe OAT, and more and more patients have accessed it. We hear of constraints to access still in rural regions. I think it's a symptom of constraints in primary care provision. We have a shortage in primary care, and I think this population is severely affected.

Much of the payment that goes into OAT goes into the pharmacies, direct witnessed ingestion fees and dispensing fees.

[*Translation*]

**The Vice-Chair (Mr. Luc Thériault):** Thank you.

Mr. Nosyk, you may finish your sentence, but there is no more time left.

[*English*]

**Dr. Bohdan Nosyk:** Okay.

**Mrs. Laila Goodridge:** You can finish your sentence.

**Dr. Bohdan Nosyk:** That was it. I finished it.

[*Translation*]

**The Vice-Chair (Mr. Luc Thériault):** Mr. Jowhari, you now have the floor for six minutes.

[*English*]

**Mr. Majid Jowhari:** Thank you, Mr. Chair.

I'd like to welcome all our witnesses.

I'm going to start with Dr. Elaine Hyshka. In your opening remarks, you talked about the shift in drug supply. I just wanted to get clarification from you, and probably a bit of expansion.

Is the shift in the drug supply an independent phenomenon? Is it a phenomenon as a result of, let's say, access to safe supply and how it might not be as readily available? Is the shift unique only to Alberta, or have you seen it across Canada?

**Dr. Elaine Hyshka:** Thank you for the question.

In my opening remarks, I referred to the staggering difference we see between 2011 and 2023. In 2011, at the height of the prescription opioid crisis—when as many as one in five Canadians reported using a medical-grade opioid, according to some surveys—we had 91 Albertans die of drug poisoning deaths, and those drugs were primarily opioids. Now, obviously, the numbers are astronomically higher than that.

What we started to see around 2012, when there was a series of very well-intended measures to limit access to prescription opioids at a population level, we saw a very dramatic decline in the population flow of prescription opioids that were either being prescribed to patients or being diverted and sold in the illegal markets.

In Edmonton, where I'm from, when I was doing my Ph.D. research in epidemiological surveys back in 2012, everyone I talked to who was using opioids was using hydromorphone pills that had either been purchased or been prescribed to them. Now that's virtually unheard of. We see so few people using those medications now. Everybody is using fentanyl.

What we believe has happened, according to the evidence we can piece together, is the decline in the prescribing of opioids corresponded with a fundamental shift in the illegal market toward novel synthetic opioids. Basically, we cracked down on prescribing, but we did not address demand. As a result, the illegal market innovated and now we have fentanyl, fentanyl's analogues, carfentanil, nitazene class opioids, fake benzodiazepines and a whole host of other very dangerous drugs that are the primary drugs circulating in the opioid supply, and it's contributing to a staggering amount of death that we have not seen before.

This trend is something we're seeing across Canada, particularly in B.C. and, later but now quite clearly, in Ontario and other parts of the country.

● (1205)

**Mr. Majid Jowhari:** This phenomenon is growing across Canada. Thank you for that.

I understand that current available treatment options and a safer supply are areas you've been looking into and doing some research on. Can you shed some light on how these available treatment options, along with a safer supply, would be able to help present an alternative to the dilemma we are faced with?

**Dr. Elaine Hyshka:** I echo everybody on the panel who has said that it is critical that we respond with a wide variety of different opioid agonist medications and options for people. We need to dramatically expand access to those medications as first-line treatments for opioid use disorder.

We also know there are some patients for whom those medications are either not an option or something they've tried and that has not been successful for them. I don't think it's okay to just say, “well, I'm sorry, but that's all we have for you.” I think it is reasonable to prescribe people prescription opioid medications in an attempt to stabilize them, support them and reduce their extreme risk of overdose death from consuming fentanyl and other toxic street drugs.

I don't think these are opposing things. I think we absolutely need on-demand, high-quality evidence-based treatment, using the full range of modalities—including injectable opioid agonist treatment, which really has not been expanded at all in our country.

That being said, there will be people for whom, for whatever reason, those medications are not an option or have not worked. We can't abandon that population. We really need to support everybody possible staying alive. It's just not acceptable to have this level of death in our country from something that is ultimately preventable.

**Mr. Majid Jowhari:** Thank you.

My last question is for you.

In your opening remarks, you talked about the societal response we need to present. You also talked about some of the wraparound services. You have about a minute. Can you clearly expand on those things?

I know you went into a number of action items. What would be the top three societal responses to help address the issue we're facing?

Thank you.

**Dr. Elaine Hyshka:** We need to treat this like an actual public health emergency. We need to invest at a scale to ensure that the effective treatments we have—like opioid agonist treatments, supervised consumption services and naloxone—are actually meeting population need. I would say there's a lack of investment in these interventions to the point where they're not scaled to meet the need in the population.

Beyond that, I think we need to look at the factors that drive drug poisoning deaths, which are increasingly housing, poverty and comorbid mental health conditions. For example, in my home province right now just under 40% of drug poisoning deaths are occurring in public places. That implies that there are a lot of people who are unstably housed or homeless. They are currently dying as a result of drugs, obviously, but also due to the fact that they're rendered so precarious in these situations by being unhoused and having no support.

I think primarily the federal government really needs to step up the level of investment and services across the country in partnership with provinces. We have just not scaled our response to anywhere what it needs to be to bring down and achieve sustained reductions in morbidity and mortality across the country.

**The Vice-Chair (Mr. Stephen Ellis (Cumberland—Colchester, CPC)):** Thank you very much, Mr. Jowhari.

[*Translation*]

Mr. Thériault, you have the floor for six minutes.

**Mr. Luc Thériault (Montcalm, BQ):** Thank you, Mr. Chair.

I thank the witnesses for their testimony.

I'll address Dr. Goyer first.

Dr. Goyer, you mentioned at the outset that the crisis was linked to contamination of the illicit drug market.

Could you elaborate? Why did you insist on pointing to this reality first?

**Dr. Marie-Ève Goyer:** If we really want to have an adequate public health response to the data circulating all over the place, we have to agree on the problem. I have a very good understanding of the history of overprescription in Canada and North America. Ms. Hyshka has just illustrated it very clearly.

Today, the majority of deaths are caused by non-prescribed substances produced by the illicit market. Given this situation, we have to ask ourselves what we can do. But I want to warn people about something. As a doctor, I fully agree with what my colleagues have just said. We really need to increase the interventions that work, such as treatments. However, we can't carry the crisis of contaminated drugs from the illicit market on our shoulders. A large number of people will never have access to treatment, either because they don't need it, or because they don't suffer from opioid dependence, or because they don't want it or haven't reached that point in their lives, or because they use recreationally, or because there are very few doctors in Canada.

As we said, access to a primary care physician is complicated for everyone. Access to a primary care physician who is trained in opioids and opioid prescription is even more complicated. Of course, we need to provide more good interventions like these, but we seem to be forgetting what's under the iceberg.

We need to question ourselves and try to find out what's going on. Why are so many people suffering from addiction? As Ms. Hyshka was saying, what are we going to do about poverty? What are we going to do about problems related to childhood trauma, mental health issues and access to housing?

Next, how are we going to deal with the illicit market? How are we going to thwart and fight the illicit market? How are we going to build on the science and experience we've gained with alcohol, tobacco and, more recently, cannabis, to go further and make the fight against the illicit market a priority? How are we going to do this in the current context for these substances?

● (1210)

**Mr. Luc Thériault:** At a previous meeting, regarding law enforcement and the fight against organized crime, some witnesses told us that the fourth pillar of the intervention plan was having very little effect; they felt we needed to consider somewhat more radical means regarding legalization.

Is that what you mean when you raise, for example, the fact that safe supply, supervised injections and supervision centres aren't enough to limit mortality and fight this incredible public health crisis that's going on right now?

**Dr. Marie-Ève Goyer:** What I'm trying to say is that there won't be a single solution to such a complex and weighty problem, a crisis involving so many deaths. Many of us have talked about existing solutions that are not being sufficiently implemented. That seems to me to be the easiest part to solve, because we know what the solutions are. We just need to implement more solutions, pour in more money and train health care professionals.

I'm going to repeat one last time that we're currently experiencing an opioid-related crisis. You can come out of medical school without knowing how to prescribe methadone. That seems inexplicable to me, and it shows the extent of the stigmatization of these clients, who are not receiving the care they need. That's the end of my sidebar.

To answer your question, there's that part, which seems pretty clear to me, at the tip of the iceberg. However, underneath the iceberg, we're actually touching the limits of the war on drugs. We've been trying to deal with it for years. We've invested thousands of dollars in the war on drugs, and we're losing even more ground. I'm not a public policy expert, but in my opinion, it's time we did things differently and looked for creative solutions.

**Mr. Luc Thériault:** Some people argue that safe supply should be stopped because it can lead to drugs being diverted onto the illegal market. That's not what you're saying. Just because there's a collateral problem doesn't necessarily mean we should end the safe supply. At the same time, you're criticizing safe supply by saying that it's not going as it should.

**Dr. Marie-Ève Goyer:** You've asked me several questions. I'll try to answer them briefly.

I think there are several false equations relative to safer supply.

First, I want to reiterate that the use of this practice is currently minimal. Few doctors use it, and few patients receive such a service. If we're really going to implement a safe supply measure, we'll need a lot more of it, as we do with other treatments.

Next, I want to say two things.

First of all, there are examples of hard drug legalization in Canada that we could learn from.

Secondly, before we even do it, let's remember that criminalization currently targets hyper-vulnerable people, who are being pushed into prisons, who are losing their housing and who have mental health problems.

I just want to tell you that we're continuing to make life more precarious for people who are currently vulnerable and already in very precarious situations. We should first consider the preliminary steps, such as reviewing the criminalization component.

● (1215)

**The Vice-Chair (Mr. Stephen Ellis):** I'm so sorry to interrupt, Dr. Goyer; time is up.

Thank you very much, Dr. Goyer and Mr. Thériault.

[*English*]

Mr. Johns, you have the floor for six minutes.

**Mr. Gord Johns:** Thank you, Mr. Chair. I want to thank all of the witnesses for their important testimony and the work they do.

Dr. Hyshka, you talked about the need for the federal government to declare a national public health emergency. It's something that the NDP has also been calling for. We saw the federal government recently host a summit on auto theft. However, it hasn't done anything like that for this crisis. You talked about how you have lost more lives in Alberta from the toxic drug crisis than COVID. Yet, we have seen the spending and effort by the federal government on the toxic drug crisis as less than 1% of that on COVID.

Do you believe the federal government is doing enough in rolling out a plan with a timeline and resources? What do you believe is necessary to respond to this crisis in the short-term?

**Dr. Elaine Hyshka:** I don't want to get bogged down in debating the specific legal mechanisms of declaring an emergency or not. Obviously, we need to recognize this for what it is, a public health emergency.

We need to substantially increase federal spending. We also need look at.... Currently, almost 60% of federal spending for the Canadian drugs and substances strategy is going towards law enforcement efforts. We need to see if that is getting us the best value for money in terms of improved population health outcomes. We are not resourcing enough, provincially or federally, social programs, health care, and a whole host of other options that can potentially be more effective at supporting people to stay alive, achieve recovery and get well.

Beyond that, in the short-term, there are many things the federal government could do immediately to try to bring down the death rate. First and foremost, please do not cut the existing funding for safer supply programs. We know, from the evidence from different treatment studies, as well as emerging safer supply evidence, that if you abruptly cut people off their prescription medications, they are at a much higher risk of death.

Sustain that funding, and continue to innovate in that area to look for more effective solutions, including non-prescriber models of safer supply. We just had a study published by a compassionate club in B.C. that showed very early and promising results in reducing mortality.

Beyond that, we could be looking to improve safer supply programs by working with pharmaceutical companies and regulators to identify medications that would more effectively meet people's needs, potentially reducing the risk for diversion.

We really need to look at a national project around decriminalization. I can't think of a stronger form of stigma than criminalizing someone. We talk a lot about needing to end stigma, but then we continue to criminalize people for their health conditions. In B.C., there is an imperfect decriminalization pilot happening. We need to have a national conversation about what this would look across the country. We need to, first and foremost, say that this is a health issue. We need to stop criminalizing people, and that needs to happen across the country. It's not fair that people who use drugs in B.C. are potentially not subject to criminal charges, but they are everywhere else.

I would also like to see an overhaul of SUAP. The way that investments are currently made is not as effective as it could be. We need to be looking at ongoing operational funding for evidence-based services as part of a core suite of options for people across the country. Federal funding could play a huge role in ensuring equitable access to treatment across the provinces, such as equitable access to safer consumption services and other really proven interventions.

I also want to highlight—and I'm not sure if the committee has heard this evidence—that in Alberta and B.C., the majority of people who die from drug poisoning are dying after smoking drugs. Yet, very few supervised consumption services across the country allow people to smoke drugs within them. A pretty quick change that could happen is for the federal government to subsidize supervised consumption services to make the renovations required to accommodate supervised inhalation.

That would have an auxiliary benefit of bringing more of the public drug use—which has been concern across the country due to a whole host of factors, including the lack of housing—indoors. It would bring that public drug use inside. Certainly, this is a big issue in Edmonton where I'm from. Many people are smoking drugs outside of supervised consumption sites, because they cannot smoke them inside. If they go down and have an overdose, they know the staff will run outside to help them. That's not an effective way to respond to a crisis. It's something that could be addressed pretty quickly in the short-term, and would save lives.

● (1220)

**Mr. Gord Johns:** Much has been made of the Alberta model that's oriented on recovery and treatment. However, recent data has highlighted that overdose rates in Alberta are rising fast since it was put in place, much faster than in British Columbia.

Can you maybe talk about why you think that is? You have about 60 seconds.

**Dr. Elaine Hyshka:** I think it's always the result of multiple factors when we're looking at trends in drug poisoning. Some things that we're seeing in our province are concerning. There's been a substantial reduction in the number of people using supervised consumption sites. It's about half of what it was before the pandemic. I think it's because of the lack of incorporating inhalation, as well as a number of the closures and relocations of the services that have disrupted connections to care for people who use drugs.

We are also seeing, as mentioned, a lot more deaths in public spaces. We need to be addressing homelessness and unstable housing. I think if people had safe places to live, with proper services and wraparound care, they wouldn't be dying of drug overdoses on our streets.

Beyond that, we have relatively low rates of opioid agonist treatment coverage for a province of our size. Only about 14,000 Albertans in quarter three of 2023 were being dispensed opioid agonist medications. That seems to be quite a low coverage rate. I think we need to also do more to expand access to opioid agonist treatments in our province.

Of course, I don't know why Alberta hasn't moved to trial a safer supply. It is potentially a very powerful tool, as Dr. Nosyk spoke to, to reduce mortality amongst the subset of people who use substances. We need to use every single tool we have to address this generational and staggering crisis.

**The Vice-Chair (Mr. Stephen Ellis):** Thank you very much, Mr. Johns and Dr. Hyshka.

We'll turn now to Dr. Kitchen for five minutes, please.

**Mr. Robert Kitchen:** Thank you, Mr. Chair.

Thank you to the witnesses for being here. I'm sorry that we had to deal with some of the protocols of the House, unfortunately, with interruptions, etc., but I appreciate your being here. You all made some significant points in your opening presentations that I think we all wanted to hear.

Dr. Goyer, you talked about something that I agree with 100%—diagnosis first, which then leads to treatment. I appreciate that comment, because I think it needs to resonate a lot more with people.

Ultimately, I think what we're looking at here is that we need to be recovery-oriented. I think that's being missed. Recovery orientation needs to be one of the biggest focuses we have. I come from Saskatchewan. I come from a very rural area. I have with me basically the OAT standards from the College of Pharmacy Professionals, as well as basically a map of what's going on in Saskatchewan right now in terms of where doctors are even trained to do it. That's a huge aspect: How do we make certain that we have that access to these rural areas? To me, I see that the focus is apparently on the big cities and not rural Canada. That's important.

Dr. Kahan, you talked a little bit about rural areas. I'm wondering if you could comment. Basically, when we look at best practices and things that we need to look at, is it valuable to be putting in a safe supply, or more so for an OAT program?

**Dr. Meldon Kahan:** I think it's unfortunate that there's been this binary discussion of safe supply or no safe supply. I don't think that's what the focus should be. I think the focus should be on ensuring that safe supply is actually safe for individual patients and the public.

This idea of prescribing large numbers of take-home tablets is actually harming people. It's leading to unnecessary and deadly bacterial infections. It's leading to diversion, which increases the use of hydromorphone and then ultimately fentanyl among youth and among people on OAT, and other problems. This can be practically and feasibly made safer by having hydromorphone tablets. The issue is not hydromorphone versus methadone. The issue is take-home versus not take-home. If you allow take-home, and people are clearly involved in the drug trade, you'll have diversion. It will harm people. Have supervised hydromorphone, supervised methadone and supervised injection opioid agonist therapy. That's what's needed.

In terms of rural communities, it really is a very bad situation, at least in Ontario. Some of the OAT providers are these large corporate chains that do not provide high-quality care. Even physicians who want to provide good care have limited access to case management and mental health resources. Some rural communities have no OAT at all. Some pharmacies neglect or refuse to dispense OAT. That is a problem. I think it's very unfortunate that SUAP has put all their resources into safer supply, yes, and other initiatives, while downplaying opioid agonist treatment. I think that needs to be changed. There needs to be a balanced approach.

● (1225)

**Mr. Robert Kitchen:** Thank you. I appreciate that. I do appreciate how, in your presentation, you've been very clear and educative as well. You talked in language that Canadians can listen to, as opposed to the researchers. That's what I think people who are watching this meeting want to hear. They want to hear it in their language, not in researchers' or technologists' language. While I may understand it, there are others who don't, so I appreciate those comments.

One of the things that was brought up in our last meeting had to do with talking about issues of dealing with pain. What I learned back many, many years ago was three steps dealing with basically pharma, psychology and physical. Those three aspects need to be addressed when dealing with patients.

I'm wondering, Dr. Goyer, I realize you have very little time, but I would like your thoughts along those lines, please.

[*Translation*]

**Dr. Marie-Ève Goyer:** When it comes to tackling complex problems, such as addiction or pain, pharmacology of course has its place. Complex problems call for complex answers. This goes back to what we were saying earlier about the importance of having a complementary set of services and care to treat chronic pain and addiction.

We need to go further than the simple pharmacological approach, including the use of physiotherapy as well as putting in place psychological services and multidisciplinary teams to manage—

[*English*]

**Mr. Robert Kitchen:** Mr. Chair, I'm sorry for interrupting, but I have a point of order.

I'd like to move a motion as amended.

**The Vice-Chair (Mr. Stephen Ellis):** Sure. Go ahead, Dr. Kitchen.

**Mr. Robert Kitchen:** I'd like to move a motion:

> That the committee invite the Minister of Health and the Minister of Mental Health and Addictions to each appear for a one-hour meeting on Supplementary Estimates (C), 2023-24, and that the Ministers appear before the end of the supply period ending March 26, 2024.

**The Vice-Chair (Mr. Stephen Ellis):** Thank you very much.

Colleagues, the difficulty, of course, is that I was the one who moved the initial motion. That makes it incredibly difficult for that to continue.

We all know that the bells are ringing at the current time. To continue this committee, we would need unanimous consent to do so. My concern, of course, is if we do not do that it will effectively be the end of the meeting, given the amount of time to get to the chamber, vote and then come back.

I am at your service as the chair of the committee. Is that the will of the committee to continue?

**Some hon. members:** Yes.

**The Vice-Chair (Mr. Stephen Ellis):** Thank you, witnesses, for understanding that there is a bit of machinery in motion here. I appreciate that.

Just so that everyone is clear, the bells are ringing in the House so there will be a vote after that. I suspect that that will probably be the end of the meeting with respect to timing, but we'll see when that comes.

At this moment, then, Madam Brière—

● (1230)

**Mr. Robert Kitchen:** To my motion—

**The Vice-Chair (Mr. Stephen Ellis):** I already said no.

[*Translation*]

Ms. Brière, you have the floor for five minutes.

[*English*]

**Mr. Robert Kitchen:** I have a point of order, Mr. Chair.

**The Vice-Chair (Mr. Stephen Ellis):** Very well, Dr. Kitchen, go ahead.

**Mr. Robert Kitchen:** I think if you canvass the room, you would see that there is unanimous consent to make that amendment.

**The Vice-Chair (Mr. Stephen Ellis):** Colleagues, I think you heard Dr. Kitchen's amendment. The problem, of course, is that I had moved the motion originally, and if there's unanimous consent we can obviously be the masters of our own destiny, and if there is.... I see heads nodding yes. There is unanimous consent.

Thank you, Dr. Kitchen.

[*Translation*]

Ms. Brière, you have the floor for five minutes.

[*English*]

**Mrs. Élisabeth Brière:** Thank you, Mr. Chair.

**The Vice-Chair (Mr. Stephen Ellis):** I am a very bad chair, obviously, and I apologize for that because we didn't vote on it. We moved it and then didn't vote on it. There's a lot of machinery on the go.

The clerk has an excellent suggestion.

Dr. Kitchen, if you could reread the motion that would be very helpful.

**Mr. Robert Kitchen:** Thank you. It reads:

> That the committee invite the Minister of Health and the Minister of Mental Health and Addictions to each appear for a one-hour meeting on Supplementary Estimates (C), 2023-24, and that the Ministers appear before the end of the supply period ending March 26, 2024.

**The Vice-Chair (Mr. Stephen Ellis):** We've all heard the text of the motion. It appears to be in order. We've had unanimous consent to move that. Do we have consent around the table that this is appropriate at the current time?

**Some hon. members:** Agreed.

(Motion agreed to)

**The Vice-Chair (Mr. Stephen Ellis):** The motion is adopted. Thank you very much.

Now that I finally have all of that out of the way, we can move back to the original business.

[*Translation*]

For the third time, Ms. Brière, I yield the floor to you for five minutes.

Thank you very much for your patience.

[*English*]

**Mrs. Élisabeth Brière:** Thank you. I hope it will be good.

[*Translation*]

Thank you so much to all the witnesses for being with us.

Dr. Goyer, since we began this study, we've heard from various witnesses that the diversion of controlled substances was due to unmet needs.

I'd like you to tell me about the reasons for this diversion. Does this have any implications for the list of drugs that are insured or reimbursed by the public system?

**Dr. Marie-Ève Goyer:** I'll try to go back over the drug diversion cognitive equation so we can all agree on the diagnosis and treatment plan.

The first thing I hear people say is that if you prescribe safe supply, there's necessarily going to be diversion. May I remind everyone that there are very few safe supply programs and very few doctors who prescribe this. If there were diversion, it would occur on a very limited basis.

In my opinion, this also contributes to the stigmatization of those who turn to this treatment. People are targeting safe supply, while doctors are prescribing a lot of drugs to patients. Some patients receive prescriptions for a month's worth of painkillers, for example. Why are we targeting the safer supply? It's not clear to me, apart from perhaps the fact that we associate drug addiction with drug diversion. Certain prejudices are tenacious: A drug addict is bound to divert. It's a connection I don't agree with.

Secondly, as Dr. Sereda has already said, among people who use, if there is diversion, it's often because there aren't enough treatments available. People try to help each other when they're going through withdrawal, when drugs are out of stock or when their pharmacy is closed on weekends. I would remind you that many pharmacies refuse to give out the medications. To me, it's not clear that this diversion is taking place.

It is assumed that the diversion of substances will target children. Again, this is based on fear. I find it dangerous to base political decisions on fear instead of relying on science and facts.

Suppose there is diversion to children. Who are these children and what are we afraid of? We're afraid they'll use and die, or we're afraid they'll end up suffering from addiction.

What do we know about children who are currently using opioids and dying from them? These children have consumed contaminated opioids from illicit markets. The British Columbia coroner's data show it. Just recently in Quebec—and this was covered in the media—a child died after consuming what he thought was a random tablet. In fact, the tablet contained isotonitazene. So, currently, it's not prescription drugs that are ending up in children's hands.

You might also wonder who the people are who are selling these substances to children. If these aren't doctor-prescribed pills, what are they selling our children? What's being sold and consumed right now are illicit tablets. These are facts.

So we keep coming back to the same two questions. First, what are we going to do about the illicit markets? That's the problem. That's what's causing deaths right now.

Secondly, if there were diversion of illicit substances to children, which remains to be demonstrated, how do we ensure that these children don't end up suffering from addiction?

Who ends up suffering from opioid addiction? It's not recreational opioid users. Opioid use falls into fertile ground when it involves people suffering from trauma or mental health disorders, people who live on the margins and who have problems related to poverty and access to housing.

We keep coming back to the same two facts. So let's aim for a treatment plan that targets the real problems: illicit markets and the social determinants of health. That's what I'm proposing.

● (1235)

**Mrs. Élisabeth Brière:** Thank you very much.

My other question concerns the recreational use of fentanyl. We heard about this from opposition MPs at our meeting last Monday.

Dr. Goyer, you've studied the concept of safe supply, and you use this treatment. Do you think there are doctors who would prescribe fentanyl to someone who isn't already addicted to contaminated drugs, or to drugs whose content is unpredictable because of the way they obtain them?

**The Vice-Chair (Mr. Stephen Ellis):** I apologize, Dr. Goyer, but time is up. I invite you to send your response to the committee in writing, if possible.

**Mrs. Élisabeth Brière:** Could you send your response to the committee in writing, Dr. Goyer?

**Dr. Marie-Ève Goyer:** Yes, I can do that, of course.

**The Vice-Chair (Mr. Stephen Ellis):** Thank you very much.

[*English*]

Colleagues, I obviously wasn't here during the last vote. My question to you now is.... There is 15 minutes before the time to vote. I understand that, last time, you left here with 10 minutes left.

Is that still what people want to do?

**Some hon. members:** Agreed.

**The Vice-Chair (Mr. Stephen Ellis):** I see general agreement. That will give us two and a half minutes each for Mr. Thériault and Mr. Johns.

[*Translation*]

Mr. Thériault, you have the floor for two and a half minutes.

**Mr. Luc Thériault:** Thank you.

In summary, there is an unprecedented crisis which is linked to contaminated illicit drugs. These give rise to overdoses and mortality, as we've seen recently.

Dr. Goyer, you said we had to realize that those who die are the most vulnerable. You mentioned that we needed to work on the social determinants of health, because these are structural vulnerabilities. That struck me. We also need to fight against illicit markets. Personally, I don't think we're doing enough on that front.

According to the current model, we seem to want the individual to go to the resource. However, if there is indeed an unprecedented public health crisis and people are dying, to intervene on the social front, we need to go to the front, where the people are, and multiply comprehensive interventions on the ground. Multidisciplinary teams need to go where the problems are. We can't wait for people to show up at a doctor's office for treatment.

What do you think?

● (1240)

**Dr. Marie-Ève Goyer:** I completely agree with you.

What you're saying is somewhat in line with the main principles of the low-threshold approach. It's about knowing who the population you want to serve is, where they are, what their needs are, and how you can reduce the barriers that prevent them from getting to the health care network. This can mean going to the people, as you said, or using community organizations, who know the terrain very well, or virtual care.

There are all kinds of barriers, and they can be geographical or financial. There are services that are covered and others that aren't, for example. However, there are also moral barriers and others related to stigmatization. We want people to feel welcome in health services, and we want to take care of them where they are, here and now. This includes people who aren't ready right away to stop using substances, and who may never be.

I can also tell you that some of my patients wouldn't be here today if they hadn't used substances to ease the terrible suffering they've experienced repeatedly over the years.

So we must also recognize that not all people are ready now to stop using substances altogether. We need to offer them a full spectrum of services, from abstinence, of course, to reducing consumption. We also need to offer them a safer supply. All these modalities must coexist. We want to reach out to everyone.

**The Vice-Chair (Mr. Stephen Ellis):** Thank you very much, Dr. Goyer.

Thank you, Mr. Thériault.

[*English*]

**Mr. Gord Johns:** Dr. Nosyk, we've heard many anecdotes about diversion, particularly to children. We haven't heard that from law enforcement.

Can you comment on this as someone conducting research on B.C.'s prescribed safer supply?

**Dr. Bohdan Nosyk:** Sure. Thank you.

We've heard statements and anecdotes about diversion. However, in British Columbia, opioid use disorder incidents have remained constant since 2020, when the safer supply program was implemented. That is true for those under 19 and overall.

Moreover—I want to stress this again—hydromorphone was detected in just 3% of all overdose-related deaths in 2022, albeit as one component among a number of substances implicated in toxicology, rather than the primary drug implicated in the overdose.

However, fentanyl was implicated in over 80% of all overdose deaths and was most commonly the primary substance indicated in toxicology reports. Make no mistake: The overdose crisis in B.C. is driven by fentanyl and its increasingly potent analogues.

**Mr. Gord Johns:** How widely has safer supply been implemented in British Columbia? It often seems, from the media on this, that it's a huge problem, but is it really? Has there been enough capacity?

You're going to have about a minute left of this whole meeting to respond.

**Dr. Bohdan Nosyk:** No, the implementation was very limited. A lot of prescribers chose to not prescribe, and many of those who did chose to add it on to OAT, as opposed to offering it as a distinct option. It was primarily prescribers located in Vancouver and Victoria who prescribed these RMG medications, at least in the first 18 months. These prescribers served larger and more severe caseloads of people with substance-use disorders. Nurse prescribers participated as well. Prescribers with a background in psychiatry were less likely to participate. Already, by the end of our study period, by August 2021, we saw prescriptions start to dissipate.

With respect to our qualitative research, I'll highlight that I work with a range of investigators from UVic and the BC Centre for Disease Control. A qualitative study from our team highlighted barriers to access in rural regions, criminalization and indication that the substances prescribed were, in many cases, insufficient and didn't entirely eliminate reliance on the drug supply.

**The Vice-Chair (Mr. Stephen Ellis):** Thank you.

Thank you, Mr. Johns.

Colleagues, we are at the time when, as I suggested, if we went and voted and came back, we would probably run out of time. Is it the will of the room to adjourn the meeting? If that would be the will, then that's great. If it's not, please let me know.

Is there a motion there?

**Mr. Gord Johns:** I think that you know my preference, Mr. Chair, that we—

**The Vice-Chair (Mr. Stephen Ellis):** I do not, actually, so—

**Mr. Gord Johns:** I'll help you. I would hope that we could vote from here and keep going. This is an important study. We could run right until 1:30, and we could try to get in a lot of questions to these very important witnesses.

● (1245)

**The Vice-Chair (Mr. Stephen Ellis):** In order to do that, we would need unanimous consent, and I do not believe we have unanimous consent.

**Mr. Gord Johns:** Have you asked for that?

**The Vice-Chair (Mr. Stephen Ellis):** I've heard noes already.

**Mr. Gord Johns:** From whom?

**The Vice-Chair (Mr. Stephen Ellis):** I don't think I need to tell you, but I've heard them.

**Mr. Robert Kitchen:** I vote no.

**The Vice-Chair (Mr. Stephen Ellis):** Mr. Kitchen is going to exercise his vote, which is that his will is to vote in person.

Colleagues, as I've said, with some going to vote in person, I would suggest to you that we will not have time to come back after that and have more testimony from the witnesses.

Do we have a motion to adjourn?

**Mr. Robert Kitchen:** I move that we adjourn.

**The Vice-Chair (Mr. Stephen Ellis):** We have a motion to adjourn from Mr. Kitchen. Is there consent around the room to adjourn the meeting?

**Some hon. members:** No.

**The Vice-Chair (Mr. Stephen Ellis):** Okay, we don't have consensus to do that either.

Very well.

The meeting is adjourned.